The World of Evidence-Based Programs (EBPs): *How to Choose & What to Expect!*

10th Annual Commonwealth of Virginia CSA Conference

October 28, 2021

10:15am - 11:45am

Your *CARE* Starts Now!

NCGcommunity.com

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Presentation Layout

I. Overview of EBPs, MST, FFT, & PCIT
II. How do I choose?
III. What outcomes should I expect?
IV. What is Success?
V. Do these services really replace wraparound?
VI. How are these programs funded?
VII. How do I hold providers accountable to ensure quality and fidelity to the model?
VIII. What other questions should I be asking?
IX. Question and Answer
X. Summary and Wrap-up

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Introduction and Overview

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Presenters

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- Evidence-Based Program Director

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Welcome Back - EBPs are rising

We continue to serve, we continue to grow, and we continue to innovate toward a better and more evidence-based system of care.

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Overview of EBPs, MST, FFT, & PCIT

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What is an Evidence Based Program (EBP)?

EBP's are programs:

- Rigorously tested in research studies
  -mostly in controlled settings by using control groups
- Deemed effective via peer reviewed research
- Demonstrated desired replicable results and outcomes
- What EBP's DON'T DO
- Activities that Move the Needle (+/-)

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Multisystemic Therapy (MST)

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What is “MST”?

Community-based, family-driven treatment for youth with a significant clinical impairment in disruptive behavior and/or substance use, with highly structured clinical supervision and QA

- Focus is on “Empowering” caregivers (parents) to solve current and future problems
- The MST “client” is the entire ecology of the youth - family, peers, school, and neighborhood

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How to Choose MST?

- Youth between 12-17* years of age at risk of severe system consequence due to serious externalizing, anti-social, and/or disruptive/delinquent behaviors

Example Behaviors	Examples of System Consequences
- Serious disrespect and disobedience behavior - Runaways - Theft and other criminal behaviors - Substance abuse/Selling substances - Chronic school absences and/or problem behaviors at school - Aggressive/violent/assaultive behavior	- Out-of-home placement (e.g. via juvenile justice, mental health, youth care, or social care) - Violation of probation - School expulsion - Child Welfare involvement

*Exceptions for youth ages 10, 11, or 18 can be requested from your MST Expert Consultant.

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How to Choose MST? (Cont.)

- Youth might present with diagnoses including, but not limited to Conduct Disorder, Oppositional Defiant Disorder, Substance Use Disorders, and/or ADHD

- Youth might also present with co-occurring needs in conjunction with anti-social behaviors
  - e.g. trauma-related symptoms, depression, anxiety, mild or moderate intellectual disability, autism spectrum disorder level 1/childhood autism based on mild difficulties

What Are Potential Service System Paths for Youth to Enter MST?

Youth who are appropriate for MST can be identified and referred via various avenues, depending on the approach of local service systems to youth with serious externalizing and/or anti-social behaviors

These avenues might include youth who are:

- Involved with Juvenile Justice, Mental Health, Social Care, and/or Child Welfare systems
- Identified via the school system
- Being diverted from placement and/or court system involvement
- Returning home from placements in justice, psychiatric, crisis, or social care facilities for disruptive/delinquent behavior or serious externalizing behavior
- Returning home from foster care placement
- Currently in foster care with a plan for permanency in that placement

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Youth Not Appropriate for MST: When Not to Choose MST

- Youth living independently
- Youth who engage in sex offending in the absence of other anti-social behavior
- Youth with moderate to severe autism

  (difficulties with social communication, social interaction, and repetitive behaviors)
- Youth severely or profoundly intellectually impaired or with a moderate, severe, or profound disorder of intellectual development (according to DSM or ICD)
- Youth who are actively homicidal, suicidal or psychotic
- Youth whose psychiatric problems are primary reason leading to referral, or who have severe and serious psychiatric problems

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MST Ultimate Outcomes: What to Expect

Referrals to MST programs 1/1/2019 – 12/31/2019

AT HOME	**92%**	These results are based on a comprehensive review of the 13,866 cases (83.8% of 16,544 cases referred to MST, MST-SA, and MST-PSB) that were closed for clinical reasons (i.e., completed treatment, low engagement, or placed).
IN SCHOOL/ WORKING	**87%**	
NO ARRESTS	**89%**	

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What makes MST work?

MST includes an emphasis on engagement with the youth's family, caregivers, and natural supports and is delivered in the recovery environment.

- MST seeks to understand the "fit" between the child's problems and the factors which contribute to them.
- Youth are observed within their network of systems including: family, peers, school and community.
- MST helps parents build supportive social networks and empowers parents to address the needs of the youth more effectively.
- MST is a rehabilitative intervention that can be used to divert higher levels of care and can also be used as a step-down.

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What to Expect with MST

- Each MST team will have a Supervisor and up to 4 therapists (2 minimum)
- Therapists Caseloads of 4-6 clients
- Length of Treatment is 3-5 months
- Rigorous focus on clinical service delivery and quality assurance/fidelity on all cases
- MST provides both therapeutic intervention and care coordination
- MST can serve as a step-down and diversion from a higher level of care
- Not all cases may be appropriate for MST
- Session frequency mirrors the needs of the family (3-5X in the beginning)
- Services occuring in the home, school, community (homeless shelter, library, etc.)
- Therapists on call 24/7 to provide safety planning and crisis intervention

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Functional Family Therapy (FFT)

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What to Expect with FFT

- Research-based prevention and trauma-informed intervention program for at-risk adolescents and their families
- Targets youth between 11-18….
  - Prevention intervention--status/diversion kids/at risk for out placement or further penetration into care systems
  - Treatment intervention--moderate and serious delinquent youth
- Short-term, family-based program
  - 12-14 sessions for moderate cases, 26-30 for more serious cases spread over 3 to 5 months
- Range of adolescent problems
  - Disruptive behavior, violence, drug abuse/use, conduct disorder, family conflict

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How/When to Choose FFT

FFT is designed for at-risk youth, ages 11-18, who have been referred for behavioral, emotional, and/or substance using problems.

FFT has shown lasting improvements in:

- Behavior and mental health
- Family conflict and functionality
- Out-of-home placements
- Substance use
- School drop-out rates
- Sibling disruptive behaviors
- Criminal recidivism

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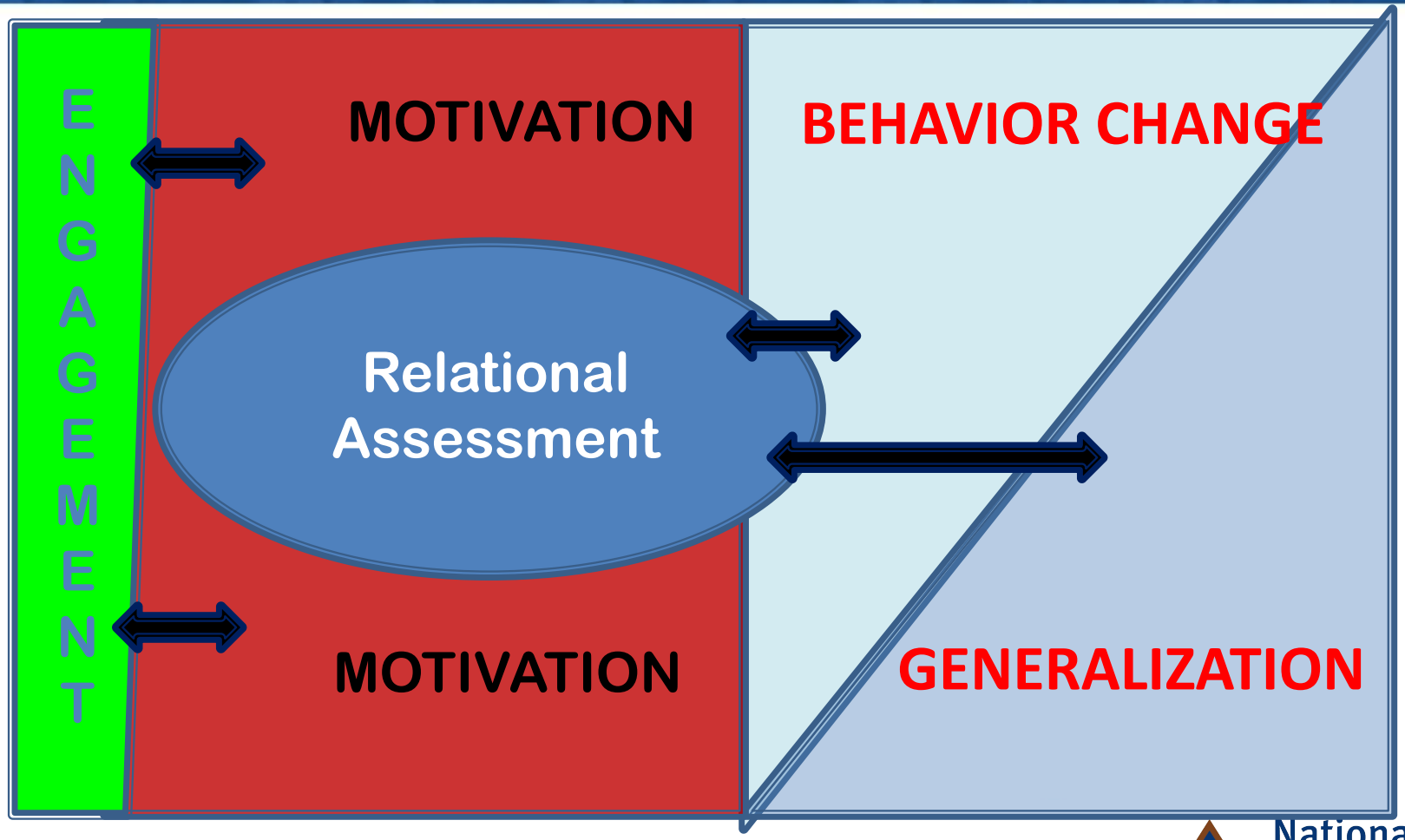
A phase-based approach….



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FFT Clinical Model

- **FFT consists of 5 Major Components or Phases:**
  1. Engagement
  2. Motivation
  3. Relational assessment
  4. Behavior change
  5. Generalization

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Referral Considerations

Inclusion Criteria

- 11 to 18 years old
- In community or ready to go into the community
- Family Available
- Youth is Returning to family
- Inclusionary referral behaviors include externalizing behaviors, internalizing symptoms, and/or substance abuse.
- Referral issues can be from one domain (externalizing alone) or in combination (co-morbidity of substance abuse and externalizing behaviors).

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Referral Considerations

Exclusion

- Youth who have no psycho-social system that constitutes family (shared history, sense of future, some level of co-habitation)
- Youth is scheduled to be sent away from family (remand, placement, foster care, etc)
- Youth with current acute psychosis.
- Youth who needs sexual offender treatment as a primary need
- Youth that present with severe psychiatric illness:
  - actively suicidal
  - actively homicidal
  - actively psychotic

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What to Expect with FFT

- Each FFT team will have a Supervisor and up to 7 therapists (3 is minimum)
- Therapists Caseloads average 10-12 clients
- Length of Treatment is 3-5 months
- Rigorous focus on clinical service delivery and quality assurance/fidelity on all cases
- Focus is on the family
- FFT can serve as a step-down and diversion from a higher level of care
- Not all cases may be appropriate for FFT
- Session frequency typically includes 3 sessions in first 10 days of treatment, then 1-2 sessions a week, depending on needs of the family.
- Services usually occurring in the home with all family members present.
- Therapists work flexible hours to meet needs of family, but there is no requirement for 24/7 on-call.

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Parent Child Interaction Therapy (PCIT)

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What is PCIT?

- Evidence-based treatment for children with disruptive behavior
  - Combines elements of attachment and learning theories, systems theory, and behavior modification
  - Involves direct coaching of parent with child
  - Assessment driven
  - Short-term treatment (avg. 14-16 weekly sessions)
    i. Average number of sessions varies from 10 to 20 sessions, with one 1-hour session per week. Treatment continues until the parent masters the interaction skills to pre-set criteria and the child's behavior has improved to within normal limits.
  - Two phases:
    i. Child Directed Interaction (CDI)
       - Positive parent-child interactions (nurturance)
    ii. Parent Directed Interaction (PDI)
       - Discipline

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Basic qualifications for PCIT

- Child is between 2 ½ and 6 ½
- Child displays/is reported to engage in negative behaviors
- Child and parent are able to communicate
- Child understands the concept of “if – then”
- Caregiver wants/needs parenting support

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PCIT HAS BEEN IMPLEMENTED WITH…

- Attention Deficit Hyperactivity Disorder (ADHD)*
- Oppositional Defiant Disorder*
- Conduct Disorders
- **Child maltreatment***
- Children with Anxiety Disorders*
- Children who witness domestic violence
- **Children in foster care***
- **Children with prenatal substance exposure or impacted by parental substance abuse***
- Mexican-American Families*
- PCIT with toddlers*
- **Children with trauma history**
- Native American Families
- Children with developmental disabilities*
- Children born prematurely*
- **Children on the Autism Spectrum***
- Children with language disorders*
- Children in military families
- Home-based PCIT*
- Group PCIT*
- Internet-based PCIT
- And more!

* At least one RCT

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So, what's the goal with PCIT?

- Increased positive parent-child interactions
  - Improved parent-child relationship
- Positive attention for positive behaviors
  - Differential social attention
  - Increase in positive child behaviors
- Effective discipline techniques
- Authoritative Parenting!

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Balances Two Factors…

1. Positive Interaction with the Child
   - Child Directed Interaction (CDI)
   - Increase positive attention
   - Decrease negative attention

2. Consistent Limit Setting
   - Parent-Directed Interaction (PDI)
   - Consistency, Predictability & Follow-Through

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PCIT IS RECOMMENDED FOR:

	Inclusion Criteria
Child (client)	○ Clinical concerns: ▪ Externalizing symptoms in the home, out-of-home placement, school, and/or community ▪ Internalizing concerns, including mood disorders ▪ Relationship and/or attachment difficulty with primary caregiver ▪ Symptomatic grief and loss ○ 2 to 6 years of age ○ Receptive language skills ≥ 24 months of age ○ Available to participate in regularly scheduled treatment sessions ○ Regular contact between client and participating primary caregiver
Primary Caregiver	○ Available to participate in regularly scheduled treatment sessions ○ Regular contact between client and participating primary caregiver

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PCIT IS NOT RECOMMENDED FOR:

	Exclusion Criteria
Child (client)	○ Receptive language skills significantly < 24 months of age ○ Unable to participate in regularly scheduled treatment sessions ○ Limited contact between client and participating primary caregiver
Primary Caregiver	○ Perpetrator of sexual abuse ○ Active perpetrator of domestic violence, physical abuse, or psychological abuse ○ Actively psychotic, significantly thought-disordered, or significantly cognitively-impaired (IQ < 65) ○ Unable to participate in regularly scheduled treatment sessions ○ Limited contact between client and participating primary caregiver

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Don’t rule out

- Children exposed to trauma
- Children in foster/kinship care
- Children/caregivers with developmental delays

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Choosing the Best EBP

We recommend when making a decision on which EBP to recommend, that you focus on four main criteria:

1. Target Population (age, placement, caregiver/parent access)
2. Target Referral Criteria/Behaviors
3. Availability of EBP in your service area
4. What EBP will the family be best vested in

Be careful to avoid a common pitfalls by relying solely on EBP session intensity/frequency

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What is Success?

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The Old Days

Referral Agency/Purchaser

"What are your outcomes?"

Provider

"85% of our youth graduate successfully from our program"

Referral agency/Purchaser

"How do you define success?"

Provider

"Umm?"

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Outcomes are Inherently Defined

- The reasons for Referral/Treatment
- Mutually accepted goals
  - Quantifiable and Measurable
- Achieving extraneous goals does not satisfy the need to achieve the goals in the plan
- Issues outside of our control do not dictate whether an outcome is valid

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EBP Specific Outcomes

MST

- Decrease in referral behaviors, out of home placements, and antisocial/delinquent behaviors
- Increase in prosocial activities

FFT

- A reduction in disruptive behavior and/or subsistence use behaviors
- increase in prosocial and functional behaviors
- an improvement in family relationships & communication

PCIT

- a decrease in externalizing child behavior problems (e.g., defiance, aggression)
- an increase in child social skills and cooperation
- an improvement in the parent-child attachment relationship.

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Success Defined

- Meeting the majority of the overarching (individual) goals determined in the beginning of treatment and documented in the plan

and

- Looking at distal outcomes, also known as long-term goals, over the course of a year after discharge in the areas of placement retention, school participation, and new engagement with the police and courts.

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Do we Need to be Perfect?

- “The Closest to perfection a person comes is when they fill out a job application form.” - Stanley Randall
- “Perfection is not attainable, but if we chase perfection we can catch excellence.” - Vince Lombardy
- “Perfection is self-abuse of the highest order.”
  - Anne Wilson Schaef
- “We were born to be real, not to be perfect.”
  - Anonymous

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Individual Goals

Individual Goals (Overarching)

- SU concerns
- Aggressive/threatening behaviors
- School functioning
- Family dynamics
- Socialization
- running away
- etc.

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Determining Goals and their Measure

- Stakeholder input and agreement
- 3 or 4 individual goals (overarching)
  - intermediary goals (micro-goals)

- Goal Attainment
  - None of the Goals
  - Some of the Goals
  - Most of the Goals
  - All of the Goals

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Ultimate Goals

- Maintaining placement
- Maintaining work and/or School
- No new arrests

Tracked after discharge:

- 3 months
- 6 months
- 12 months

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Do these services really replace wraparound?

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The Problem with Wraparound

- 13 years of conditioning
  - We must target every behavior
- The cost
  - Financial
  - Where is the evidence?
  - What about consistency?
  - A heavy toll on the family

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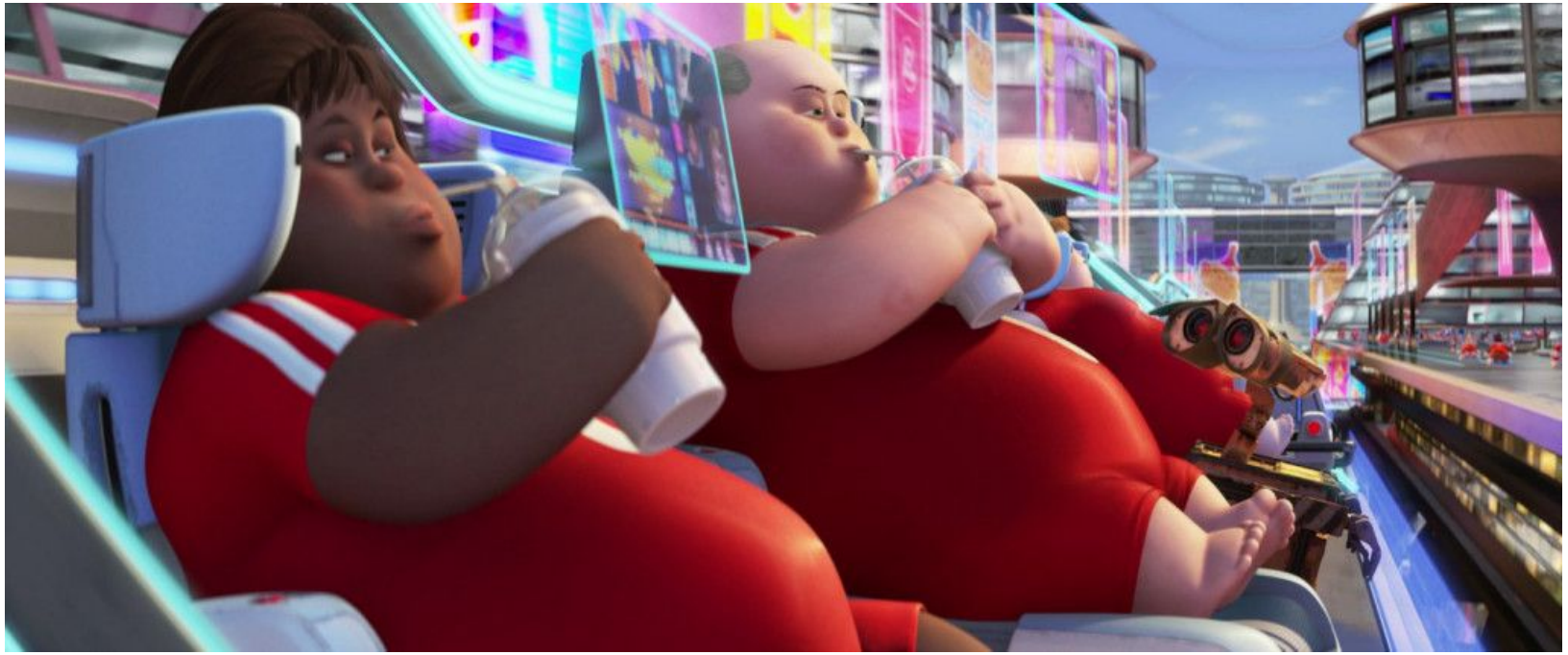
Unintended Consequences

- Reliance on the service



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con’t

- Lack of interest/engagment

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Concurrent Services which are Excluded

MST

- Individual therapy (MST Prefers to that OP only take place if MST has shown to need this adjunct)
- Therapeutic mentoring
- Parenting skill-building
- Group or family therapy
- ARTS Levels 2.1, 2.5, 3.1, and 3.3-4.0
- Community Stabilization
- Functional Family Therapy (FFT)
- Mental Health Skill-Building (MHSS)
- Intensive In-home Services (IIH)
- MH Partial Hospitalization
- MH INtensive Outpatient (IOP)
- Assertive Community Treatment (ACT)

***Therapeutic Day Treatment (TDT) is allowed**

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Concurrent Services which are Excluded

FFT

- Parenting skill-building
- Group or family therapy
- ARTS Levels 2.1, 2.5, 3.1, and 3.3-4.0
- Community Stabilization
- Multisystemic Therapy (MST)
- Mental Health Skill-Building (MHSS)
- Intensive In-home Services (IIH)
- MH Partial Hospitalization
- MH INtensive Outpatient (IOP)
- Assertive Community Treatment (ACT)

***TDT, Individual Therapy, and Therapeutic Mentoring are allowed**

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Concurrent Services which are Excluded

PCIT

That should not be any prohibited services under PCIT as it is an OP therapy model.

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To Wrap or not to Wrap

Maybe?

- If allowable by the EBP and DMAS:
  - Is it practical
  - Are they interested in more services?
  - Is it in their best interest?

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How Does Funding Work?

- CSA & DJJ
- Average local FAPT share
  - 16.5 cents on the dollar
    - FFT = $10/day (Total Cost = $1,128/120 days)
    - MST = $15/day (Total Cost = $1,782/120 days)
    - PCIT = $3.5/day (Total Cost = $630/6 months)

Compared to:

- GH = $92/day (Total Cost = $16,790/6 months)
- RTC = $143/day (Total Cost = 26,098)/6 months)

***Residential expenditures are based on FY21 DMAS and typical education rates.**

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Additional Funding

- Family First Prevention Act
  - Implemented on July 1, 2021
  - Allows for IV-E funds to fully remibures for these services if:
    - The child is IV-E Eligible
    - They are at risk of out of home placement
    - MST, FFT, or PCIT is used
- DMAS
  - Effective December 1, 2021

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How do I hold providers accountable and ensure quality and fidelity to the model?

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QA & Fidelity Monitoring

1. Be aware of each models QA & Fidelity Processes
   - MST- TAM, SAM, PIR
   - FFT- Weekly Supervision Checklist, Global Therapist Ratings, TYPE Report
   - PCIT- DPICS

2. Participate in Stakeholder meetings (during implementation &/or routine program reviews)

3. Review Stakeholder Fidelity Reports (MST- PIR every 6 months) FFT- TYPE Report every 4 months

4. Ask Questions

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What other questions should I be asking?

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Questions to Ask:

- Is your EBP program licensed by the proper model developers/approved agency?
  - https://www.mstservices.com/our-community
  - https://www.fftllc.com/sites/
  - http://www.pcit.org/find-a-provider1.html
- What is your service area? (90 min drive time rule)
- What is your service/referral capacity & availability?
- Do you have a waitlist? If so, what other services can help stabilize this family during that period?
- Do you track post discharge outcomes? if so, what is the success rate?
- What if a youth/family is not being successful in treatment?
- If a case discharges successfully and experiences post discharge, what can be done?

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Summary & Wrap-up

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Summary & Wrap-Up

- EBPs are a game changer
  - Fidelity across providers and practitioners
  - Systemic oversight
  - Scientific corroboration
- EBPs improve service delivery
  - Insightful referrals
  - Predictable outcomes
  - Purchaser insight
  - Provider accountability

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Q&A

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Resources

Drafted DMAS Level of Care Guidelines: https://www.dmas.virginia.gov/media/3815/mhs-appendix-d-8-30-2021-draft-1.pdf

MST Research: https://www.mstservices.com/mst-reports-research

FFT Research: https://www.fftllc.com/about-fft-training/fft-research.html

MST Outcomes; https://www.mstservices.com/proven-results

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For future questions about EBPs

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Session Evaluation Link

Please use the link in the chat section to complete the session evaluation for this workshop.

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